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	155379	A. BUILDING 00 B. WING	04/18/2011

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LIFE CARE CENTER OF ROCHESTER	827 WEST 13TH STREET ROCHESTER, IN46975

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: April 11, 12, 13, 14, 15, and 18, 2011 Facility number: 000325 Provider number:155379 AIM number: 100274300 Survey team: Julie Wagoner, RN, TC Honey Kuhn, RN (04/11 and 12, 2011) Angie Strass, RN Tim Long, RN (04/11, 12, 13, 14, and 15, 2011) Census bed type: SNF/NF: 100 Total: 100 Census payor type: Medicare: 14 Medicaid: 64 Other: 22 Total: 100 Sample: 20 Supplemental sample: 01 These deficiencies also reflect state findings cited in accordance with 410 IAC	F0000	Please accept the following plan of correction for the annual survey completed on April 18, 2011. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	16.2. Quality review completed 4/26/11 by Jennie Bartelt, RN.			
F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on record review and interview, the facility failed to ensure there was	F0272	Infections for resident #72 had previously resolved. Chart reviews were completed for	05/16/2011

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	thorough follow up assessments regarding a urinary tract infection and a vaginal yeast infection for 1 of 5 residents reviewed for infection in a sample of 20. (Resident #72) Finding includes: The clinical record for Resident #72 was reviewed on 04/15/11 at 10:30 A.M. The resident was admitted to the facility on 02/11/11, with diagnoses including, but not limited to, diabetes, end stage renal disease, and MRSA (Methicillin-resistant Staphylococcus aureus) infection to a wound. The resident's physician orders on admission included the antibiotic, Levaquin, to treat the MRSA infection in a heel wound. Physician orders, dated 02/21/11, included orders to obtain a urinalysis lab test via a catheter. Nurse's notes, dated 02/22/11, indicated the laboratory specimen was obtained and sent to the laboratory. A nursing note, dated 02/23/11 at 2:00 P.M., indicated the urinalysis results were received and a "uti" (urinary tract infection) was apparent. The physician was notified and indicated no additional antibiotic needed to be ordered as the resident was already on the antibiotic,		all residents who had urinary track infections or vaginal yeast infections since 4/18/2011 to ensure thorough follow-up assessments were completed. Licensed nurses were re-educated by the Director of Nursing and Staff Development Coordinator on May 4, 2011; education included review of policy and procedure for completion of follow-up assessments regarding infections. DON or designee will audit thorough completion of follow-up assessments for urinary track infections and vaginal yeast infections during "Change of Condition" meeting at least three (3) times per week for four (4) weeks and continue weekly for no less than two (2) additional months. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as indicated.	

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	Levaquin to treat her heel wound. In addition, an order was received on 02/23/11, per the resident's request, for medication due to her history of "vaginal yeast infections" for the antifungal medication, Diflucan 100 mg, to be given once a day for 7 days. The nurse's notes from 02/23/11 - 03/01/11 indicated a daily temperature was obtained and documented, but there was no thorough assessment of the resident's urine color, clarity, or odor, and only scattered documentation of assessment of any discomfort or frequency. In addition, there was no documentation of any signs and symptoms of the resident's vaginal yeast infection. Interview with the Director of Nursing on 04/18/11 at 11:00 A.M., indicated there was no thorough assessment located for either the urinary tract infection or the yeast infection. She indicated it appeared the staff focused on the antibiotic use for the wound infection and neglected to document much about the resident's urinary tract infection. 3.1-31(a)			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to obtain a laboratory test as ordered by a physician for 1 of 20 residents reviewed for physician orders (Resident #14) in a sample of 20. Findings include:	F0282	Resident #14's physician did not want to repeat the C&S as the patient was asymptomatic. Chart reviews were completed for all residents who had laboratory tests ordered by a physician since 4/18/2011 to ensure completion of laboratory tests as ordered. Unit Managers were re-educated by the Director of Nursing on May 10, 2011; education included review of follow-up procedures to ensure labs are completed as ordered by the physician. DON or designee will audit completion of lab tests as ordered by the physician during "Change of Condition" meeting at least three (3) times per week for four (4) weeks and continue weekly for no less than two (2) additional months. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95%	05/16/2011

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	Resident #14's clinical record was reviewed on 4/14/11 at 11:25 A.M. The record indicated the resident was admitted to the facility on 3/23/11 and had diagnoses including, but not limited to, hydronephrosis and depression . A physician's order was received on 3/24/11 for an urinalysis (UA) to be completed monthly. The facility obtained an UA on 3/29/11 and the results indicated some abnormals. On 3/30/11 the physician was notified and orders were received to start Cipro (an antibiotic) 500 mg (milligrams) by mouth twice daily for 10 days and to obtain a C & S (culture and sensitivity) of the urine. The laboratory results did not indicate the resident had a C & S completed. An interview with RN #1 on 4/14/11 at 2:20 P.M. indicated the C & S was never obtained, and she indicated she had contacted the resident's physician who did not was to repeat the C & S as the patient was asymptomatic. 3.1-35(g)(2)		compliance threshold prior to discontinuing audits. Plan to be updated as indicated.	

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F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure the resident received timely assistance with feeding based on his mealtime needs. The deficient practice affected 1 of 5 residents who required feeding assistance in a sample of 20. (Resident #97) Finding includes: During observation of the noon meal service, conducted on 04/11/11 between 12:35 P.M. through 12:55 P.M., Resident #97, who was seated at a table by himself on the assisted side of the dining room, had received his meal tray between 12:35 P.M. - 12:40 P.M. The resident was noted to have his head down and his eyes closed and made no attempt to feed himself from 12:40 - 12:50 P.M. There were no staff noted to attempt to feed him or cue him to wake up and feed himself. During observation of the evening meal, conducted on 04/13/11 between 5:10 P.M.	F0312	All residents receive timely assistance with feeding based on his or her mealtime needs. Resident indicated was moved to a different table to better assist with meals on April 15, 2011. All residents needing assistance with feeding were reviewed to ensure timely assistance with feeding was provided based on his or her mealtime needs. Nursing staff were re-educated by the Director of Nursing and Staff Development Coordinator on May 5, 2011; education will include provision of timely assistance to residents that have feeding needs. DON or designee will audit meals to ensure timely assistance is provided to residents with feeding needs at least eight (10) times per week for one month and continue weekly for no less than two (2) additional months. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95%	05/16/2011

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	- 5:55 P.M., Resident #97 was served him meal tray 5:15 P.M. by the Maintenance Supervisor. The resident was awake when he was served him meal and had been attempting to drink from large insulated mugs with lids prior to receiving his meal. The resident was noted to promptly fall asleep and spill the large mug of chocolate all over his shoes and the floor underneath his table. He remained asleep without any cues or assistance from staff from 5:25 P.M. - 5:52 P.M., when a nursing staff member realized he was sleeping, sat down, woke the resident and fed him his supper. The resident was noted to accept the food and assistance. Interview with the Unit Manager, LPN #9, on 04/11/11 at 11:00 A.M. indicated Resident #97 had end stage Alzheimer's disease, required the assistance of two staff for most activities of daily living and required to be fed at times. The clinical record for Resident #97 was reviewed on 04/14/11 at 9:45 A.M. The resident had diagnoses including, but not limited to, Alzheimer's disease. The most recent Minimum Data Set (MDS) assessment, completed on 02/03/11, indicated the resident had declined and now required extensive		compliance threshold prior to discontinuing audits. Plan to be updated as indicated.	

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	assistance for eating needs. The most recent health care plan, reviewed as current as of 03/08/2011, indicated the resident's goal was to complete self feeding tasks. Interventions included: verbal cueing and prompting to feed himself, placing him close to the table, offering utensils as the resident would attempt to utilize his fingers, and monitoring the resident's ability to feed himself. Interview with the Director of Nursing, on 04/18/11 at 9:30 A.M. indicated the resident was moved to a different table so staff could more easily provide any assist the resident might need. 3.1-38(a)(2)(D)			
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, observation, and interview, the facility failed to ensure safe use of a mechanical lift for a resident who had stiffness and impaired range of	F0323	The facility ensures safe use of mechanical lifts when transferring residents and thoroughly investigates falls involving mechanical lifts to identify causal	05/16/2011

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	motion. The resident was dropped from the lift to the floor. The facility failed to thoroughly investigate the cause of the fall to plan for prevention of other falls. This deficient practice affected 1 of 5 residents reviewed for falls in a sample of 20. (Resident #18) Resident #18 fell from the lift and received a laceration to the head requiring sutures. Finding includes: The clinical record for Resident #18 was reviewed on 04/12/11 at 10:25 A.M. An acute care center history and physical, dated 09/15/10, indicated the resident had been treated for a scalp laceration caused by being dropped from a mechanical lift. The most recent Minimum Data Set (MDS) assessment for Resident #18, completed on 01/20/11, indicated she required total staff assistance for transferring needs and had impaired upper and lower extremity range of motion. Interview with LPN #8, during the initial tour of the facility, completed on 04/11/11 between 10:30 - 11:45 A.M. indicated the resident required transferring assistance from two staff and utilized a mechanical lift. Review of the Incident Follow-Up and Recommendation Form, completed on		factors and prevent reoccurrence. All residents requiring the use of a mechanical lift were reviewed to ensure the correct procedures were followed. All residents that have fallen since 4/18/2011 were reviewed to ensure fall investigations were completed to thoroughly investigate the cause of the fall to plan for prevention of other falls. Nursing staff were re-educated by the Director of Nursing and Staff Development Coordinator on May 5, 2011, on the proper use of the mechanical lift when transferring residents. Licensed nurses were re-educated by the Director of Nursing and Staff Development Coordinator on May 4, 2011, education included review of the policy and procedure on completion of fall investigations with additional focus to thoroughly investigate the cause of the fall to plan for prevention of other falls. DON or designee will audit the proper use of a mechanical lift during resident transfers at least five (5) times per week for four (4) weeks and continue weekly for no less than two (2) additional months. DON or designee will audit to ensure the facility thoroughly investigated the cause of a fall to plan for prevention of other falls at least five (5) times weekly for four (4) weeks and continue weekly for no less than two (2) additional months. The results of these audits will be	

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	09/15 and 09/16/10, regarding the fall for Resident #18 on 09/15/10, indicated the following: "Resident slid out of Hoyer while being transferred. Rec'd (received) laceration to head...Res transferred to ER (emergency room) for eval rec'd 12 sutures to head. CNA's to be re-educated of proper use of Hoyer. will have maint (maintenance) check function of Hoyer lift." Interview with the Director of Nursing, on 04/13/11 at 9:30 A.M. indicated the maintenance had checked all the lifts in the facility and found no mechanical issues. When queried regarding whether the proper type of lift pad was being utilized at the time of the fall, wether the pad had been placed on the proper or same "loop", if the condition of the lift pad was checked, and how the resident and pad were noted when the nurse was called to the room, as well as statements from the two CNA staff, she indicated there were statements from the CNA's which did not indicate anymore information except that the resident had a tendency to roll to her left side and was "stiff." She indicated there had been no documentation regarding the position or condition of the lift pad because the resident's injuries had taken precedence when the nurse had entered the room.		presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 100% compliance threshold prior to discontinuing audits. Plan to be updated as indicated.	

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	Observation of a transfer from bed to chair for Resident #18, conducted on 04/15/11 at 10:55 A.M. by CNA #10 and CNA #11, indicated a "full body" lift pad was utilized and the Hoyer mechanical lift was also utilized. The resident was noted to be thin, kept her arms contracted, and did tend to lean or list to her left side. Interviews with both CNA's indicated the "full body" lift pad was designated for Resident #18 due to her "stiffness." They indicated it was not "written" but both CNA's had been shown which lift pad to utilize when they were trained. 3.1-45(a)(2)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, record review, and interviews, the facility failed to ensure there was adequate monitoring for 1 of 7 resident reviewed for psychotropic medications in a sample of 20. (Resident #66) In addition, the facility failed to ensure there was adequate indications to support a medication dose increase for 2 of 7 residents reviewed for medication use in a sample of 20. (Resident #66 and 97) Findings include: 1. The clinical record for Resident #66 was reviewed on 04/12/11 at 9:10 A.M. Resident #66 was admitted to the facility	F0329	There was a medication reduction for resident #66 and #97 and a behavior monitoring program was initiated for resident #66. All residents currently receiving psychotropic medications were reviewed to evaluate the need for implementation of a behavior monitoring program and all residents with an increase in psychotropic medications since 4/18/2011 were reviewed to ensure there were adequate indications to support a medication dose increase. Licensed nurses were re-educated by the Director of Nursing and Staff Development Coordinator on May 4, 2011; education included review of the	05/16/2011

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	from another long term care facility on 03/01/11, with diagnoses, including but not limited to, depressive disorder, anxiety, and questionable bipolar disorder. The resident had physician's orders on admission for the psychotropic medication, Seroquel 25 mg twice a day and the anti-depressive medication, Prozac 40 mg once a day. Interview with LPN #8, during the initial tour of the facility on 4/11/11 from 10:30 to 11:45 a.m., indicated the resident "yelled out" instead of utilizing the call light. The resident was evaluated by the facility's psychiatric consultant group on 03/28/11. The physician's nurse practitioner's progress note indicated the resident was reported to "yell" a lot and had a possible resident to resident altercation. The report indicated the resident indicated she was not sleeping well. The nurse practitioner increased the resident's Seroquel medication to 100 mg at bedtime and added the mood stabilizing medication, Depakote 250 mg twice a day for two weeks and then increased to 250 mg three times a day. Review of the behavior monitoring record indicated it was not initiated until 03/14/11 and the resident's verbally		behavior management program. The Social Services Director or designee will be responsible to review psychotropic medication use for necessary behavior monitoring programs one (1) unit per week for three (3) months. The Director of Nursing or designee will audit psychotropic medication changes during "Change of Condition" meeting to ensure there are adequate indications to support a psychotropic medication dose increase at least three (3) times per week for four (4) weeks and continue weekly for no less than two (2) additional months. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as indicated.	

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	abusive behavior was to be monitored. There was one episode of continuous unclear behavior documented on 03/19/11 with successful interventions of giving a drink, reassurance, validation of feeling/support, and reproaching later utilized. There was no documentation of alternatives attempted prior to increasing the resident's Seroquel medication and adding the additional Depakote medication. 2. Resident #97 was observed during the noon meal on 04/11/11 and 04/14/11 seated in his wheelchair at the dining room table with his head down asleep. The resident was noted at the evening meal on 04/13/11, seated in his wheelchair at the dining room table asleep. The resident was observed on 04/13/11 and 04/14/11 between meals, lying in his bed asleep. The clinical record for Resident #97 was reviewed on 04/14/11 at 9:30 A.M. The resident had diagnosis, including but not limited to, Alzheimer's dementia. The physician's orders indicated the resident was receiving the antidepressant medication, Tofranil 25 mg, twice a day. Nurse's notes, dated 03/19/11 at 1:45 P.M., 4:00 P.M., and 11 P.M., indicated the resident was exhibiting combative,			

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	155379	A. BUILDING 00 B. WING	04/18/2011

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	aggressive behavior and was agitated and yelling at staff. Nurse's notes, dated 03/22/11 at 11:00 A.M., indicated the resident did not want to get up and was combative with care and refused to eat breakfast. Nurse's note, dated 03/22/11 indicated the physician was notified of the resident's behavior and doubled the resident's antidepressant medication. Review of the behavior monitoring record and health care plans for Resident #97, current as of 03/08/2011, indicated the resident was to be monitored for verbally abusive behavior and was receiving the Tofranil medication for agitation and depression. Interventions for behaviors included, but were not limited to, snack, drink, move to quiet area, turn on gospel music, encourage to sit or rest, remove from source of agitation, reproach later, approach by alternate caregiver, offer male caregiver, listen to electric piano. There was only one behavior episode documented on the monitoring record form for February 23, 2011. There were no behaviors documented for March or April 2011. Thus, there was no alternative documented as having been attempted or documentation the resident's care plan			

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	approaches to behaviors were attempted prior to notifying the physician and increasing the resident's Tofranil medication. 3.1-48(a)(3) 3.1-48(a)(4)			
F0365 SS=D	Each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to provide a "finger food" diet for 1 of 1 resident (Resident #4) reviewed for eating needs in a supplemental sample of 1. Findings include: On 4/13/11 at 5:47 p.m., Resident #4 was observed seated in the dining room eating a fruit parfait with her fingers. The parfait was noted to be pudding consistency. During observation of Resident #4 on 4/14/11 at 11:50 a.m., the resident was seated at the table in the dining room. The resident had a bowl of soup in front of her, which had not been eaten. Staff	F0365	The facility Speech Therapist developed recommendations of appropriate finger foods specific for resident #4 to be incorporated into her modified mechanical soft diet. All residents that have recommendations for the use of "finger foods" were reviewed to ensure finger foods were being provided as indicated. Dietary staff were in-serviced by the Registered Dietician and the Director of Nutrition Services on 4/25/2011 on the provision of finger foods for a mechanical soft diet. Dietary staff were in-serviced on May 9, 2011 by the Speech Therapist and Registered Dietician, education included review of finger food recommendations for resident indicated and procedure for preparation of the finger foods.	05/16/2011

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	delivered the resident's tray which had a stroganoff over rice, oriental vegetables,garlic bread and a dish of apricots. The resident was observed to pick up the garlic bread and start to eat. Approximately 5 minutes later a staff person, CNA #13 sat down and started to feed the resident. Observation of the resident's meal ticket indicated she was on a regular mechanical soft diet and finger foods. CNA #13, who was feeding the resident, was interviewed at this time, about the "finger foods" listed on the meal ticket and was asked if the resident would feed herself. CNA #13 indicated the resident will feed herself finger foods. CNA #13 went to the kitchen and returned with dry cereal and a fruit bar which the resident proceeded to eat herself. On 4/14/11 at 12:45 p.m., the Dietary Manager was interviewed about the resident's finger food diet. He indicated the corporation does not have a finger food diet. On 4/15/11 at 9:45 a.m. interview with the Consultant Registered Dietitian indicated the corporation does not have a finger food diet as this would be nutritionally limiting to resident's.		The Director of Nutrition Services will audit to ensure finger foods are incorporated into a resident's meal as indicated at least ten (10) times per week for four (4) weeks and continue weekly for no less than two (2) additional months. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as indicated.	

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	On 4/18/11 at 11:00 a.m., interview with the Registered Dietician indicated the resident had an order to incorporate finger foods into her diet. Review of Resident #4's clinical record on 4/15/11 at 2:00 p.m., indicated the resident was admitted to the facility on 7/1/07 and had diagnoses including but not limited to mental disorder, chronic pain, aphasia and muscle weakness. The resident also was receiving hospice services due to her dementia. Physician orders, dated 4/20/10, indicated the resident was to receive a mechanical soft diet and offer hand held foods whenever possible. Review of a physician's order from hospice, dated 3/25/11, indicated, "Please incorporate finger foods into current diet orders." Both orders were still on the resident's current physician's orders for April 2011. 3.1-21(a)(3)			

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation and record review, the facility failed to ensure staff removed contaminated gloves after resident care for 3 of 3 residents observed for care needs in a sample of 20. (Residents #88,	F0441	Nursing staff ensure the proper removal of contaminated gloves during provision of resident care. All residents requiring assistance with personal care are at risk to be affected.	05/16/2011

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	#34, and #59) Findings include: 1. On 4/12/11 at 11:30 a.m., observation of certified nursing assistants (CNA'S) #2 & #3, were giving care to Resident #88. CNA #2 removed the resident's wet brief, washed the resident with disposable washcloths. CNA #2 then assisted CNA #3 with pulling up the resident's pants, took the blanket and covered the resident, then pulled the resident up in the bed. CNA#2 then took the pillow and placed it under the resident's head, and with her contaminated glove brushed the resident's hair back from her forehead and then removed her gloves. 2. On 4/14/11 at 11:00 a.m. CNA #3 was observed in the shower room with Resident #59. With gloved hands the CNA removed the resident's wet brief. She then removed the resident's pants, socks and gait belt and placed the pants, socks and gait belt on top of the clean towels without removing her contaminated gloves. 3. On 4/15/11 at 11:00 a.m., CNA #2 was observed to be providing care for Resident #34. With gloved hands CNA #2 removed the resident's wet brief, and cleaned the resident front and back with		Nursing staff were provided re-education with return demonstration by the Staff Development Coordinator on May 4-5, 2011 regarding the proper removal of contaminated gloves during resident care. The Director of Nursing or designee will randomly audit the proper removal of contaminated gloves during resident care at least eight (8) times per week for four (4) weeks and continue weekly for no less than two (2) additional months. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as indicated.	

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	disposable wash cloths. CNA #2 then applied a clean brief to the resident and put the resident's pants back on without removing her contaminated gloves. On 4/18/11 at 9:30 a.m., review of the facility policy for "Using Gloves" dated 5/21/04, indicated disposable gloves must be replaced as soon as practical when contaminated. 3.1-18(l)			